GRAVEN & ASSOCIATES

psychology • neuropsychology

Child/Adolescent New Patient Information Form

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

School Name _____ Current Grade Level _____ Date of Birth _____ / _____ / _____

Preferred Method of Contact (please select one) □ Home Phone □ Cell Phone

If there is a legal custody agreement and/or legal guardianship appointment, you are required to provide this to the office PRIOR TO your first appointment

Parents' Marital Status _____ Is there a legal custody agreement? □ Yes □ No □ Currently Pending □ N/A
Who has legal custody and the power to make healthcare decisions? _____

DEMOGRAPHIC INFORMATION

Preferred Language _____ □ Decline to specify **Race** _____ □ Decline to specify

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to specify

PARENT INFORMATION

PARENT 1	PARENT 1
Name _____	Name _____
Address _____	Address _____
Date of Birth _____ / _____ / _____ Age _____	Date of Birth _____ / _____ / _____ Age _____
Home (_____) _____ - _____ Cell (_____) _____ - _____	Home (_____) _____ - _____ Cell (_____) _____ - _____
Marital Status □ Single □ Married □ Separated □ Divorced	Marital Status □ Single □ Married □ Separated □ Divorced
Stepparent's Name (if applicable) _____	Stepparent's Name (if applicable) _____

REFERRAL INFORMATION

Whom may we thank for referring you to our office? _____

Address _____ Phone (_____) _____ - _____ Fax (_____) _____ - _____

Signing below indicates that the above information is true and accurate.

_____ _____
Patient Name Date

_____ _____
Patient Signature (if age 16 or older) Parent/Legal Guardian Signature
Authorized Representative Relationship/Authority *(CIRCLE ONE):* Self Parent Guardian Other:_____

INFORMED CONSENT FOR TREATMENT

Welcome to Graven & Associates, PLLC. This document contains important information about our professional services and business policies. When you sign this document, it will represent an agreement between us. Please read it carefully.

MINORS

If you are under 16 years of age, please be aware that Kentucky law provides your parents the right to examine your treatment records and requires patients age 16 or above to sign all forms in addition to a parent/guardian. If this is a concern, please visit with your provider about this during your first visit. **Further, any patient under the age of 16 is required to have a parent/legal guardian present on the premises during all appointments.** Should a patient under the age of 16 present to the office for treatment without a parent/guardian or other previously authorized individual present, providers are unable to treat the patient. Should this occur, parent/legal guardian may be subject to a late cancellation fee of $75.00.

I, _____ (PRINT PATIENT/PARENT/LEGAL GUARDIAN NAME), hereby agree and consent to participate in treatment/testing services provided by my Graven & Associates provider. I also agree and consent that Graven & Associates providers can consult with each other about treatment/testing or referrals within Graven & Associates. If the patient is under the age of 16 (as per Kentucky law) or unable to consent to treatment, I attest that I have legal custody of this individual and am legally authorized to initiate and consent for treatment on behalf of this individual.

_____ _____

Patient Name Date

_____ _____

Patient Signature (if age 16 or older) Parent/Legal Guardian Signature

Authorized Representative Relationship/Authority *(CIRCLE ONE):* Self Parent Guardian Other:_____

APPOINTMENTS

Our providers normally conduct a 45- to 60-minute intake evaluation. During this time, you can work with your provider to decide if they are the best person to provide the services you need in order to meet your treatment goals. You can discuss with them the frequency and type of therapy (i.e., individual, couples, family) that would be most beneficial to reduce your symptoms. Once an appointment time is scheduled, you will be expected to pay for it unless you provide 48 hours (2 day) advance notice of cancellation unless you and your provider agree that you were unable to attend due to circumstances beyond your control. Appointments scheduled for Monday must be cancelled by 4:00 PM on Friday. Please do not come to the office sick—this fee is waived in the event of illness or other circumstances at the discretion of Graven & Associates. Work, school and/or social obligations are not considered circumstances beyond your control. Insurance does not pay for missed sessions. *In addition, appointment reminders are a courtesy and it is your responsibility to know the date and time of your appointment.*

INSURANCE

It is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, it is your responsibility to know what your insurance policy covers and you (not your insurance company) are responsible for full payment of your provider's fees. Further, your provider is not on every insurance panel so it is important that you verify the provider's participation in your network if you will be using your insurance benefits. Ultimately, you are responsible for maintaining coverage through your health insurance. You should also be aware that most insurance companies require you to authorize your provider to provide them with a clinical diagnosis. Sometimes your provider has to provide additional clinical information such as treatment plans, summaries of treatment, copies of an evaluation, or the entire record. By signing this Informed Consent for Treatment, you are giving Graven & Associates consent to provide treatment information to your insurance company.

PROFESSIONAL RECORDS

The laws and regulations of this profession require that your provider keeps treatment records. You are entitled to receive a copy of your records, or your provider can prepare a summary for you instead unless precluded from doing so by federal or state law. Because these are professional records, they can be easily misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them in your provider's presence so that the contents can

be discussed. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

CONTACTING YOUR PROVIDER

Your provider may not be immediately available by telephone, but will make every effort to return your call within 24 to 48 business hours. When they are unavailable, Graven & Associates administrative team are happy to take a message for your provider or place you in their voicemail. If your provider will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary. If you are unable to reach your provider and feel that you can't wait for them to return your call, call 911 or go to the nearest emergency room and ask for the psychologist or psychiatrist on call.

ELECTRONIC COMMUNICATION CONSENT

Electronic communication offers an efficient way to communicate with Graven & Associates. However, this medium is not without its risks. Communication by telephone, cell phone, text, mail, email, websites, fax, and the like are not secure and thus do not guarantee confidentiality. Though your provider takes many steps to protect confidentiality, if you choose to contact your provider via one of these methods, you are accepting the risk that a third party may intercept our communication. Graven & Associates will not be liable for improper disclosure of confidential information that is not caused by our intentional misconduct.

GUIDELINES FOR USE OF ELECTRONIC COMMUNICATION AND APPOINTMENT REMINDER INFORMATION

- Phone calls are NOT appropriate for urgent matters or an emergency situation; instead please call 911 or go to your nearest emergency room.
- Providers typically check messages on a regular basis, however there may be exceptions to this. Most calls are returned within 24 to 48 business hours.
- Graven & Associates is not liable for breach of confidentiality caused by the patient or any third party.
- You are responsible for informing your provider of changes in your contact information including address, email, and phone numbers.
- Please do not request contact or connection with your provider via social media sites such as Facebook or Linked In. This is potentially a violation of your confidentiality and outside the boundaries of the therapeutic relationship.
- Graven & Associates will not email and/or text patients unless it is a means to confirm appointments. The best way to communicate with your provider is via phone, mail, or fax.

Please mark the appropriate selection below.

□ I **consent** to receive text/email appointment reminders from Graven & Associates at the following cell number and/or email address: _____.
I understand that I may revoke this consent at any time by notifying Graven & Associates in writing of my decision. I understand that this service is a courtesy offered to me and that I am responsible for remembering my scheduled appointment and may be subject to fees if I do not provide a cancellation notice of 48 hours.

□ I **decline** to receive text/email appointment reminders from Graven & Associates. I understand that I may change this decision at any time by notifying Graven & Associates in writing of my decision. I understand that I am responsible for remembering my scheduled appointment time and may be subject to fees if I do not provide a cancellation notice of 48 hours.

OVERVIEW OF CONFIDENTIALITY POLICIES

In general, the privacy of all communications between a patient and a psychologist are protected by law, and your provider can only release information to others with your written permission/authorization. Your provider's general rule, should you see each other outside the office, is to not indicate your provider knows you unless you acknowledge your provider. To prevent a possible breach in confidentiality with awkward introductions, please avoid approaching your provider in public if they are with someone else.

There are a few exceptions to the rule of confidentiality. In most legal proceedings, you have the right to prevent your provider from providing any information about your treatment. Your provider will inform you if they receive a subpoena for your records. In some proceedings involving child custody and those in which your emotional condition is an important issue, a

judge may order your provider's testimony if he/she determines that the issues demand it. Additionally, filing insurance claims with your insurance provider, though they contain little clinical information, constitutes confidential protection.
There are some situations in which your provider is legally obligated to take action to protect others from harm, even if your provider has to reveal some information about a patient's treatment. For example, if your provider believes that a child, elderly or disabled person, or another vulnerable adult is being neglected or abused, your provider is required to file a report with the appropriate state agency. By law health care providers MUST report these situations, without exception.

If your provider believes that a patient is threatening serious bodily harm to himself/herself or another person or group of persons, your provider is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, your provider may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. By law health care providers MUST report these situations, without exception.

This summary of the confidentiality standards of Graven & Associates is provided to emphasize the important information found in the Graven & Associates Notice of Privacy Practices. **Please review the Graven & Associates Notice of Privacy Practices carefully for a complete description of your rights concerning your protected health information and how Graven & Associates will use and disclose your protected health information.**

WRITTEN CONSENT TO RELEASE INFORMATION FOR PAYMENT AND HEALTHCARE OPERATIONS

"Protected health information" or "PHI" refers to information about you that may identify you and relates to your past, present or future mental or physical health or condition and related health services.

In an effort to facilitate the payment for services that you receive from Graven & Associates and our operations related to your care, Graven & Associates seeks your informed written consent for the use and disclosure of your PHI by Graven & Associates, PLLC for the limited purposes of (a) obtaining payment for your psychological and related services from insurers, Medicare, Medicaid and others, as applicable, and (b) supporting the business activities of Graven & Associates, PLLC, including but not limited to, for quality assessment and improvement activities, case management and care coordination, employee review activities, training and supervision of psychological students or psychologists with temporary licensure, and conducting or arranging for other business activities such as audits and administrative services.

Except as provided in the Graven & Associates Notice of Privacy Practices and required or permitted by law, all other releases of your PHI will be made only with your specific authorization.

I, _____ **(PRINT PATIENT/PARENT/LEGAL GUARDIAN NAME)**, hereby permit Graven & Associates and the psychologists or other healthcare professionals involved in my care to use and disclose my protected health information for the payment and healthcare operations activities described above and in more detail in the Graven & Associates Notice of Privacy Practices.

Further, I specifically acknowledge and agree that my Graven & Associates provider may use and disclose my PHI to employees of Graven & Associates under the supervision of my provider where such employee becomes involved in my care by virtue of assisting my provider with healthcare diagnosis or treatment at the request of my provider.

I also acknowledge that I have read the information in this document and agree to abide by its terms during the professional relationship. **Additionally, I acknowledge that I was provided the opportunity to review and/or obtain a copy of the Graven & Associates Notice of Privacy Practices.**

Signing below indicates that the above information is true and accurate.

_____ _____
Patient Name Date

_____ _____
Patient Signature (if age 16 or older) Parent/Legal Guardian Signature
Authorized Representative Relationship/Authority *(CIRCLE ONE):* Self Parent Guardian Other:_____

PROFESSIONAL FEE POLICY

Charges for services are due and payable in full at the time the services are rendered. If you have health insurance coverage, a claim form will be filed on your behalf. In the event the insurance rejects your claim, the amount paid is based on Graven & Associates, PLLC regular fee schedule. You are responsible for paying the balance owed on your account immediately. Your account can be settled using cash, check or credit card. If a statement remains unpaid after sixty (60) days and no satisfactory arrangements have been made, we will pursue collection to the fullest extent permitted by law, which may include the account being sent to collections or small claims court. The cost of any such proceedings will be included in the claim.

Your appointment time is reserved especially for you and you must cancel with 48-hours' notice to avoid a cancellation charge. Regarding *therapy appointments*, if you cancel without 48-hours' notice or miss an appointment, you will be charged $75. However, regarding *testing appointments*, if you cancel without 48-hours' notice or miss an appointment, you will be charged $75 per hour you were scheduled to be in the office. Please do not come to the office sick—this fee is waived in the event of illness or other circumstances at the discretion of Graven and Associates, PLLC. Work, school and/or social obligations are not considered circumstances beyond your control.

There is a $55.00 charge for each fifteen (15) minutes of a telephone consultation lasting longer than five (5) minutes. There is a $50.00 charge for the provider's time required for filling out paperwork related to disability claims, etc. Patients requesting a second copy of their record may be expected to pay $1.00 per page. Insurance companies will not pay for these fees. (Paperwork required by your insurance company for services rendered is *not* subject to this fee.) Additional copies of any evaluation conducted are $25.00. Once a proper written request for medical records has been received records will be produced within thirty (30) days. However, if they are needed within two (2) weeks, then you have the option of paying an expedited processing fee of $250.00.

If you become involved in legal proceedings that require your provider's participation, you will be responsible for their professional time. Because of the difficulty of legal involvement, you are expected to pay a flat fee of $1450.00, which covers the first two hours of court or deposition appearance and one hour of preparation time/phone calls as well an administrative fee. This fee MUST be paid prior to your provider's appearance. Additional time will be billed at $400.00 per hour for preparation work and $500.00 per hour for attendance at any legal proceedings. Insurance companies will not pay for this fee. All legal fees are non-refundable.

In the event that an overpayment is made, the patient or parent/legal guardian will be contacted as soon as all claims have been processed. Reimbursements will be issued in the form of a check from Graven & Associates. This check will be mailed to the patient or parent/legal guardian via USPS.

In the event that this check is lost or misplaced, the check will be re-issued to the patient or parent/legal guardian. A $50.00 processing fee will be deducted from the reimbursement and the patient or parent/legal guardian will be required to come into the office during normal business hours to receive the check. A $50.00 processing fee will be charged for checks returned by the bank due to nonsufficient funds. Further, we reserve the right to request to have the patient or parent/legal guardian pay for future sessions by credit card or cash if a check has been returned.

By signing below, I attest that I understand and agree to the professional fee policy. I am aware that I am ultimately responsible for any charges incurred for services rendered. It is my responsibility to inform this office of any changes to my insurance or billing information.

_____ _____

Patient Name Date

_____ _____

Patient Signature (if age 16 or older) Parent/Legal Guardian Signature

Authorized Representative Relationship/Authority *(CIRCLE ONE):* Self Parent Guardian Other:_____

MEDICATION LIST

Please list any and all medications that you are currently taking, including prescription medications, over-the-counter medications, vitamins, supplements, etc. **Please note that it is YOUR responsibility to inform your provider of any changes to this list as soon as they occur.**

□ Medication list to be provided at next visit. □ Written list provided today. □ No medications currently taken

Medication Name	Dosage	Reason Prescribed	Prescribing Doctor

Signing below indicates that the above information is true and accurate.

_____ _____

Patient Name Date

_____ _____

Patient Signature (if age 16 or older) Parent/Legal Guardian Signature

Authorized Representative Relationship/Authority *(CIRCLE ONE):* Self Parent Guardian Other:_____